SLEEP APNEA
PRELIMINARY UNDERWRITING QUESTIONNAIRE

Client: **Gender:** M◯F◯ **DOB:**
Height: **Weight:**

Coverage Desired? **Amount?** **Plan Desired?**

If your client has sleep apnea, please answer the following:

SLEEP APNEA HISTORY

1. **What was the date of the initial treatment or diagnosis?**
2. **Was the sleep apnea diagnosed as:**
   - ☐ Obstructive
   - ☐ Central
   - ☐ Mixed
   - ☐ Unknown
3. **How is the Sleep Apnea treated?**
   - ☐ Observation alone
   - ☐ Weight loss
   - ☐ CPAP mask
   - ☐ Surgery
   - ☐ Other, please give details:
4. **Has your client had any of the following?** *Select all that apply.*
   - ☐ Lung disease
   - ☐ Overweight
   - ☐ Chest pain or coronary artery disease
   - ☐ Arrhythmia
   - ☐ Stroke
   - ☐ Depression

CURRENT STATE

5. **Please list current medications:**
6. **Has your client smoked cigarettes in the last 12 months?** ◯Yes◯No
7. **Does your client have any other major health problems (*ex: heart disease, etc.*)?** ◯Yes◯No

   If yes, please give details:

Please note the date of the most recent sleep apnea study and attach a copy of the report.
Date:

ADDITIONAL COMMENTS

Do you have any additional comments?

Advisor:

Date:

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